LUSK EYE SPECIALISTS

PATIENT REGISTRATION

PATIENT INFORMATION DATE_____/_____/_____

Were you referred by an optometrist? _____YES_____NO

If Yes, then whom?_____

If No, then who may we thank for referring you_____

Primary Care Physician_____

Check One: Mr.____ Mrs.____ Ms.____ Dr.____ Rev.____

Name:(Last)_____First_____MI____

Home Phone (_____)_____-_____

Work Phone (_____)_____-_____

Cell Phone (_____)_____-_____

Address_____Apt#_____

City_____State_____Zip_____

Sex: Male_____ Female_____ Age_____ Birthday_____/_____/_____

Martial Status: Single_____ Married_____ Widowed_____Divorced_____

Patient's Social Security Number_____-_____-_____

Patient's Occupation_____

Patient's Employer_____

Employer's Phone_____

Patient's E-Mail Address_____

SPOUSE INFORMATION

Spouse's Name_____

Social Security Number_____-_____-_____

Spouse's Work Phone(_____)_____-_____

EMERGENCY CONTACT(SOMEONE NOT LIVING AT YOUR ADDRESS)

Name_____

Relationship_____

Home Phone(_____)_____-_____

Work Phone(_____)_____-_____

INSURANCE INFORMATION

Who is responsible for your account?_____

Primary Insurance Company_____

Secondary Insurance Company_____

ASSIGNMENT AND RELEASE INFORMATION
(Please read and sign)

I certify that I, or my dependent, has insurance coverage with the insurance companies listed above and hereby assign directly to James E. Lusk, M.D., all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges incurred regardless of payment by my insurance company or companies**. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance submissions.

X_____ _____/_____/_____
Responsible Party's Signature

NOTICE OF PRIVACY PRACTICES

I have received Lusk Eye Specialists' Notice of Privacy Practices.

X_____ _____/_____/_____
Signature Date

MEDICARE AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made to Lusk Eye Specialists for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Important to Medicare Recipients

The performance of a refraction (a fitting for glasses) is not covered by Medicare (Section 1862 (s) (7). Please remember that you will be charged a separate refraction fee at the time of your visit.

Patient's Signature X_____Date_____/_____/_____

FOR OFFICE USE ONLY

	PACHS	ADJUSTMENT
OD		
OS		

Tech's Initials_____

PROCEDURE	OD	DATE	OS	DATE
Phaco w/IOL	____	_____	____	_____
SLT	____	_____	____	_____
PKP	____	_____	____	_____
Trabeculectomy	____	_____	____	_____
Yag	____	_____	____	_____
Lasik PRK	____	_____	____	_____
_____	____	_____	____	_____

Allergy Sticker

MEDICAL HISTORY

Date of Last Eye Exam_____/_____/_____ By Who?_____

1. Have you ever been treated for any medical condition

YES	NO	
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Stroke
☐	☐	Arthritis
☐	☐	Asthma/Emphysemia
☐	☐	AIDS
☐	☐	Cancer (including skin cancer)
☐	☐	Heart Disease
☐	☐	Heart Attack
☐	☐	Tuberculosis (TB)

2. Have you ever been hospitalized or had any type of surgical procedure performed on you? Yes_____ No_____
   If Yes, Please list_____
3. Are you presently taking any medication? Yes_____ No_____ If Yes, Please List_____
   _____
4. Are you allergic to any medications? Yes_____No_____ If Yes, Please List_____
   _____

EYE HEALTH HISTORY (Please check all diseases and symptoms that apply to you)

Cataract _____ Glaucoma _____ Macular Degeneration _____ Diabetes _____

Retinal Detachment _____ Retinal Tears _____ Previous cataract SX _____ Previous Injury/Trauma _____

REVIEW OF SYSTEMS Do you currently have any of the following problems? **(If Yes, Please Explain)**

Y N	1.	Chronic fever, unexpected weight loss/gain, fatigue, blood disorders:_____
Y N	2.	Ear/Nose/Throat problems, hearing loss, sinus problems, sore throat:_____
Y N	3.	Heart problems, chest pain, irregular heartbeat, pacemaker:_____
Y N	4.	Respiratory problems, shortness of breath, wheezing, coughing:_____
Y N	5.	Gastrointestinal problems, heartburn, abdominal pain, diarrhea, vomiting:_____
Y N	6.	Urinary problems, kidney disease, kidney stones, pain, discomfort, blood in urine:_____
Y N	7.	Skin problems, rashes, excessive dryness:_____
Y N	8.	Musculoskeletal problems, muscle aches, arthritis, joint pain, swollen joints:_____
Y N	9.	Neurological problems, numbness, weakness, headaches, paralysis, dizziness:_____
Y N	10.	Psychiatric problems, depression, anxiety:_____
Y N	11.	Are you currently pregnant? If Yes, how many months?_____
Y N	12.	Do you currently use tobacco? If Yes, how often?_____
Y N	13.	Do you currently consume alcoholic beverages? If Yes, how often?_____

FAMILY HISTORY Does anyone in your family have a history of medical or eye disease? Explain and check any that apply:

YES	NO		List family member
☐	☐	Glaucoma	_____
☐	☐	Cataracts	_____
☐	☐	Diabetes	_____
☐	☐	High Blood Pressure	_____
☐	☐	Macular Degeneration	_____
☐	☐	Heart Disease	_____

Because I have Glaucoma, Diabetes, or other chronic eye disease(s), I realize that I must have my eyes examined at least every six months

Patient's Signature_____Date_____/____/____Witness'Signature_____Date____/____/____

OFFICE USE ONLY **NOTES:**

MD **OD**